or because transfer would be unreasonable, given the distance and the nature of the medical condition.

Geographic area means the area found by CMS to be the area within which the HMO or CMP furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Medicare enrollee means a Medicare beneficiary who has been identified on CMS records as an enrollee of an HMO or CMP that has a contract with CMS under section 1876 of the Act and subpart L of this part.

New Medicare enrollee means a Medicare beneficiary who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part; and

(2) Was not enrolled with the HMO or CMP at the time he or she became entitled to benefits under Part A or eligible to enroll in Part B of Medicare.

Risk contract means a Medicare contract under which CMS pays the HMO or CMP on a risk basis for Medicare covered services.

Risk HMO or CMP means an HMO or CMP that has in effect a risk contract with CMS under section 1876 of the Act and subpart L of this part.

Urgently needed services means covered services that are needed by an enrollee who is temporarily absent from the HMO's or CMP's geographic area and that—

(1) Are required in order to prevent serious deterioration of the enrollee's health as a result of unforeseen injury or illness; and

(2) Cannot be delayed until the enrollee returns to the HMO's or CMP's geographic area.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 51986, Oct. 17, 1991; 58 FR 38072, July 15, 1993; 60 FR 45675, Sept. 1, 1995]

§ 417.402 Effective date of initial regulations.

(a) The changes made to section 1876 of the Act by section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 became effective on February 1, 1985, the effective date of the initial implementing regulations.

(b) No new cost plan contracts are accepted by CMS. CMS will, however, accept and approve applications to modify cost plan contracts in order to expand service areas, provided they are submitted on or before September 1, 2006, and CMS determines that the organization continues to meet regulatory requirements and the requirements in its cost plan contract. Section 1876 cost plan contracts will not be extended or renewed beyond December 31, 2007, where conditions in paragraph (c) of this section are present.

(c) *Mandatory HMO or CMP and contract non-renewal or service area reduction.* CMS will non-renew all or a portion of an HMO's or CMP's contracted service area using procedures in §417.492(b) and §417.494(a) for any period beginning on or after January 1, 2008, where-

(1) There were two or more coordinated care plan-model MA regional plans in the same service area or portion of a service area for the entire previous calendar year meeting the conditions in paragraph (c)(3) of this section; or

(2) There were two or more coordinated care plan-model MA local plans in the same service area or portion of a service area for the entire previous calendar year meeting the conditions in paragraph (c)(3) of this section.

(3) *Minimum enrollment requirements.* (i) With respect to any service area or portion of a service area that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to the Metropolitan Statistical Area, 5,000 enrolled individuals.

(ii) With respect to any service area or portion of a service area that is not within a Metropolitan Statistical Area described in paragraph (c)(3)(i) of this section, 1,500 individuals.

[63 FR 35066, June 26, 1998, as amended at 65 FR 40314, June 29, 2000; 67 FR 13288, Mar. 22, 2002; 70 FR 4713, Jan. 28, 2005]

§ 417.404 General requirements.

(a) In order to contract with CMS under the Medicare program, an entity must—

(1) Be determined by CMS to be an HMO or CMP (in accordance with §§117.142 and 417.407, respectively); and

(2) Comply with the contract requirements set forth in subpart L of this part.

(b) CMS enters into or renews a contract only if it determines that action would be consistent with the effective and efficient implementation of section 1876 of the Act.

[60 FR 45675, Sept. 1, 1995]

§417.406 Application and determination.

(a) *Responsibility for making determinations.* CMS is responsible for determining whether an entity meets the requirements to be an HMO or CMP.

(b) *Application requirements.* (1) The application requirements for HMOs are set forth in §417.143.

(2) The requirements of §417.143 also apply to CMPs except that there are no application fees.

(c) *Determination.* CMS uses the procedures set forth in §417.144(a) through (d) to determine whether an entity is an HMO or CMP.

(d) *Oversight of continuing compliance.* (1) CMS oversees an entity's continued compliance with the requirements for an HMO as defined in §417.1 or for a CMP as set forth in §417.407.

(2) If an entity no longer meets those requirements, CMS terminates the contract of that entity in accordance with §417.494.

[60 FR 45675, Sept. 1, 1995]

§417.407 Requirements for a Competitive Medical Plan (CMP).

(a) *General rule.* To qualify as a CMP, an entity must be organized under the laws of a State and must meet the requirements of paragraphs (b) through (f) of this section.

(b) *Required services*—(1) *Basic rule.* Except as provided in paragraph (b)(2) of this section, the entity furnishes to its enrollees at least the following services:

(i) Physicians' services performed by physicians.

(ii) Laboratory, x-ray, emergency, and preventive services.

(iii) Out-of-area coverage.

(iv) Inpatient hospital services.

(2) Exception for Medicaid prepayment risk contracts. An entity that had, before 1970, a Medicaid prepayment risk contract that did not include provision of inpatient hospital services is not required to provide those services.

(c) *Compensation for services.* The entity receives compensation (except for deductibles, coinsurance, and copayments) for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee.

(d) *Source of physicians' services.* The entity provides physicians' services primarily through—

(1) Physicians who are employees or partners of the entity; or

(2) Physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physicians' services.

(e) *Assumption of financial risk.* The rules set forth in §417.120(b) for HMOs apply also to CMPs except that reference to ''basic services'' must be read as reference to the required services listed in paragraph (b) of this section.

(f) *Protection of enrollees.* The entity provides adequately against the risk of insolvency by meeting the requirements of §§417.120(a) and 417.122 for protection of enrollees against loss of benefits and liability for payment of any fees that are the legal responsibility of the entity.

[60 FR 45675, Sept. 1, 1995]

§417.408 Contract application process.

(a) *Contents of application.* (1) The application for a contract must include supporting information in the form and detail required by CMS. (2) Whenever feasible, CMS exempts the HMO or CMP from resubmittal of information it has already submitted to CMS in connection with a determination made under the provisions of §417.406.

(b) *Approval of application.* (1) If CMS approves the application, it gives written notice to the HMO or CMP, indicating that it meets the requirements for either a risk or reasonable cost contract or only for a reasonable cost contract.

(2) If the HMO or CMP is dissatisfied with a determination that it meets the requirements only for a reasonable cost